ANTIDEPRESSANT MEDICATION TABLE

Refer to pharmaceutical manufacturer's literature for full prescribing information

SEROTONIN SELECTIVE REUPTAKE INHIBITORS (SSRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Citalopram	Celexa	20 mg	60 mg	Reduce dose for the elderly & those with renal or hepatic failure	No serious systemic toxicity even after substantial overdose. Drug interactions may include tricyclic antidepressants, carbamazepine & warfarin.	Nausea, insomnia, sedation, headache, fatigue dizziness, sexual dysfunction anorexia, weight loss, sweating, GI distress, tremor, restlessness, agitation, anxiety.	Response rate = 2 - 4 wks	AM daily dosing. Can be started at an effective dose immediately.
Fluoxetine	Prozac	20 mg	80 mg					
Paroxetine	Paxil	20 mg	50 mg					
Sertraline	Zoloft	50 mg	200 mg					

First Line Antidepressant Medication
Drugs of this class differ substantially in safety, tolerability and simplicity when used in patients on other medications. Can work in TCA nonresponders. Useful in several anxiety disorders. Taper gradually when discontinuing these medications. Fluoxetine has the longer half-life.

SEROTONIN and NOREPHINEPHRINE REUPTAKE INHIBITORS (SNRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Venlafaxine IR	Effexor IR	75 mg	375 mg	Information Not Available	No serious systemic toxicity. Downtaper slowly to prevent clinically significant withdrawal syndrome. Few drug interactions.	Comparable to SSRIs at low dose. Nausea, dry mouth, insomnia, somnolence, dizziness, anxiety, abnormal ejaculation, head-ache, asthenia, sweating.	Response rate = 2 - 4 wks (4 - 7 days at ~300 mg/day)	BID or TID dosing with IR. Daily dosing with XR. Can be started at an effective dose (75 mg) immediately.
Venlafaxine XR	Effexor XR	75 mg	375 mg					

Dual action drug that predominantly acts like a Serotonin Selective Reuptake inhibitor at low doses and adds the effect of an Norepinephrine Selective Reuptake Inhibitor at high doses. Possible efficacy in cases not responsive to TCAs or SSRIs. Taper dose prior to discontinuation.

SEROTONIN (5-H2A) RECEPTOR ANTAGONIST and WEAK SEROTONIN REUPTAKE INHIBITORS

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Nefazodone	Serzone	200 mg	600 mg	Reduce dose for the elderly & those with renal or hepatic failure	No serious systemic toxicity from OD. Can interact with agents that decrease arousal/impair cognitive performance and interact with adrenergic agents that regulate blood pressure.	Somnolence dizziness, fatigue, dry mouth, nausea, headache, constipation, impaired vision. Unlikely to cause sexual dysfunction.	Response rate = 2 - 4 wks	BID dosing. Requires dose titration.
Trazodone	Desyrel	150 mg	600 mg					

Corrects sleep disturbance and reduces anxiety in about one week.

DOPAMINE and NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Bupropion - IR	Wellbutrin - IR	200 mg	450 mg	Reduce dose for the elderly & those with renal or hepatic failure	Seizure risk at doses higher than max. Drug/drug interactions uncommon.	Rarely causes sexual dysfunction.	Response rate = 2 - 4 wks	BID / TID dosing. Requires dose titration.
Bupropion - SR	Wellbutrin - SR	150 mg	400 mg					

Least likely antidepressant to result in a pt becoming manic. Do not use if there is a history of seizure disorder, head trauma, bulimia or anorexia. Can work in TCA nonresponders.

TRICYCLIC ANTIDEPRESSANTS (TCAs) – Mainly Serotonin Reuptake Inhibitors

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Amitriptyline *	Elavil, Endep *	50 - 100 mg	300 mg	Reduce dose for those with renal or hepatic failure	Serious toxicity can result from OD. Slow system clearance. Can cause multiple drug/drug interactions.	Sedation, increased anticholinergic effects, orthostatic hypotension, cardiac conduction disturbances, arrhythmia & wt gain, dizziness, sexual dysfunction.	Response rate = 2 - 4 wks Therapeutic Levels: Imipramine 200-350 ng/mL	Can be given QD. Monitor serum level after one week of treatment.
Imipramine *	Tofranil *	75 mg	300 mg					
Doxepin *	Sinequan *	75 mg	300 mg					

These antidepressants are not recommended for use in the elderly.
Highest response rates. TATCAs useful in chronic pain, migraine headaches & insomnia.

* Tertiary Amine Tricyclic Antidepressants (TATCAs).

TRICYCLIC ANTIDEPRESSANTS (TCAs) – Mainly Norepinephrine Reuptake Inhibitors

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Desipramine *	Norpramin *	75 - 200 mg	300 mg	Reduce dose for the elderly & those with renal or hepatic failure	Serious toxicity can result from OD. Reserve Maprotiline as a second-line agent due to risk of seizures at therapeutic & nontherapeutic doses.	Generally Good	Response rate = 2 - 4 wks Therapeutic Levels: Desipramine 125-300 ng/mL Nortriptyline 50-150 ng/mL	Can be given QD. Can start effective dose immediately. Monitor serum level after one week of treatment.
Nortriptyline	Aventyl/Pamelor	50 mg	150 mg					

Consider Desipramine or Nortriptyline first in the elderly if TCAs are necessary.

* Secondary Amine Tricyclic Antidepressants (SATCAs)

VHA/DoD Clinical Practice Guideline Management of Major Depressive Disorder (MDD) in Adults in the Outpatient Mental Health Specialty Setting

Evaluate for serious immediate needs
Dangerousness, unsafe living situation, substance abuse, psychosis, untreated medical condition - handle as needed before continuing MDD assessment and treatment

↓

Assess for MDD
Use DSM-IV criteria for diagnosis; include other testing as needed (e.g. Beck Depression Inventory, CES-D)

The following must be present for at least two weeks:

Depressed mood most of day, nearly every day
Markedly diminished interest or pleasure in activities most of day, nearly every day
} **At least one one must be present**

4 or more must be present
- Weight loss when not dieting or weight gain or decrease/increase appetite
- Insomnia or hypersomnia
- Psychomotor retardation or agitation
- Fatigue; loss of energy
- Feeling of worthlessness, guilt
- Diminished ability to think or concentrate, indecisiveness
- Recurrent thoughts of death, suicidal ideation, suicidal plan or attempt

Assess current MDD treatment if patient referred from other provider; adherence, response, and side effects

↓

Provide education, discuss treatment options, and jointly choose therapy
Educate patient and, if appropriate, family
Discuss options: Empirically supported psychotherapy; medication; combination

↓

Provide therapy as planned with patient and interdisciplinary team
Evaluate patient response every 1-2 weeks
If no improvement in 6 weeks, reevaluate, considering other MDD treatments and possible undiagnosed comorbid conditions
If improving, continue current treatment up to 12 weeks

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Expected remission around 12 weeks after initiation of therapy
If remitted at 12 weeks, institute maintenance plan
If improving, but not remitted, continue therapy with timetable for expected remission
If not improving or not remitted after expected time exceeded, reevaluate, considering other MDD treatments and possible undiagnosed comorbid conditions

Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and Patient Care Services and DoD.

VA access for guidelines:
http://www.oqp.med.va.gov/cpg/cpg.asp

DoD access for guidelines:
http://www.cs.amedd.army.mil/Qmo

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NATIONAL CPG COUNCIL

ONGOING PATIENT ASSESSMENT AND MONITORING

Symptoms of Major Depressive and Dysthymic D/O — "SIG E CAPS"

- **S** Sleep disorder*
- **I** Interest deficit
- **G** Guilt, worthlessness*, hopelessness* regret
- **E** Energy deficit*; fatigue
- **C** Concentration deficit*
- **A** Appetite disorder* -either increased or decreased
- **P** Psychomotor retardation or agitation
- **S** Suicidality

Note: To meet a diagnosis of major depression, a patient must have 4 of the symptoms plus depressed mood or anhedonia for at least 2 weeks. To meet the diagnosis of dysthymic disorder the patient must have 2 of the 6 symptoms marked with an asterisk (*) plus depressed mood for at least 2 years.

SAD PERSONS: ***Suicide risk factors***

- **S** Sex: Males are more likely to kill themselves than females by more than 3 to 1
- **A** Age: Older greater than younger, especially Caucasian males
- **D** Depression: A depressive episode precedes suicide in up to 70% of cases
- **P** Previous attempts: Most people who die from suicide do so on their first or second attempt. Patients who make multiple (4+) attempts have increased risk for future attempts rather than completion.
- **E** Ethanol use: Patients who abuse substances are at increased risk for suicide completion.
- **R** Rational thinking loss: Profound cognitive slowing, distorted perceptions, psychotic depression, pre-existing brain damage.
- **S** Social Support deficit: May be a result of illness, which can cause social withdrawal, loss of job, loss of relationship, legal difficulties.
- **O** Organized plan: Always inquire about the presence of a suicide plan.
- **N** No spouse: May be a result or cause of a depressive disorder.
- **S** Sickness: Intercurrent medical illness.

MONITORING TOOL SENSITIVE TO WEEKLY CHANGES

Center for Epidemiological Studies - Depression Scale (CES-D)
5-item brief version developed as a screening instrument for patients of all ages and 60 or over:

For each of the following, please indicate how often you felt that way during the past week, using the following ratings **(Total score of 4 or more is a positive depression screen):**

Score for question 1 - 4 only

Rarely or none of the time (less than one day)	0
Some or a little of the time (1 to 2 days)	1
Moderately or much of the time (3 to 4 days)	2
Most or almost all the time (5 to 7 days)	3

Item#	Question	Score
1.	I felt that I could not shake off the blues even with help from my family or friends	0 1 2 3
2.	I felt depressed	0 1 2 3
3.	I felt fearful	0 1 2 3
4.	My sleep was restless	0 1 2 3

Score for question 5 only

Most of the time	0
Moderately or much of the time	1
Some of the time	2
Rarely	3

5.	I felt hoeful about the future.	0 1 2 3

This screening instrument is derived from the CES-D (Lewinsohn, et al., 1997).

DSM-IV - COMMON MOOD DISORDERS (not inclusive)
D E P R E S S I V E D I S O R D E R S

DSM-IV Code	DIAGNOSIS	DESCRIPTION / CRITERIA
296.2x	**Major Depressive Disorder, Single Episode**	A. Five (or more) of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. **Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.** (1) depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (2) markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day, as indicated by either subjective account or observation made by others (3) significant weight loss when not dieting or weight gain (a change of more than 5% of body weight in a month), or decrease/increase in appetite nearly every day (4) insomnia or hypersomnia nearly every day (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (6) fatigue or loss of energy nearly every day (7) feelings of worthlessness, or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) (8) diminished ability to think or concentrate, or indecisiveness, nearly every day, (either by subjective account or as observed by others) (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide B. The symptoms do not meet criteria for a Mixed Episode. C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The symptoms are not due to the direct physiological effects of a substance (drug of abuse/medication) or a general medical condition (hypothyroidism). E. The symptoms are not better accounted for by Bereavement.
296.3x	**Major Depressive Disorder, Recurrent**	Any condition classifiable as **296.2** that is recurrent. See above description.
300.4	**Dysthymic Disorder**	A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least two years. B. Presence, while depressed of two or more of the following: (1) poor appetite or overeating (2) insomnia or hypersomnia (3) low energy or fatigue (4) low self-esteem (5) poor concentration or difficulty making decisions (6) feelings of hopelessness C. During the two year period the person has never been without the symptoms of A or B for more than 2 months at a time. D. No Major Depressive Episode has been present during the first two years of the disturbance; the disturbance is not better accounted for by chronic Major Depressive Disorder or Major Depressive Disorder, in Partial Remission. E. There has never been a Manic Episode, a Mixed Episode or a Hypomanic Episode and criteria has never been met for Cyclothymic D/O. F. Disturbance does not occur exclusively during course of a chronic Psychotic D/O. G. The symptoms are not due to the direct physiological effects of a substance (drug of abuse/medication) or a general medical condition (hypothyroidism). H. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

DSM-IV 5th Digit Subclassification Codes: Add to 296.0 to 296.6 where the "x" is located

0 Unspecified	1 Mild	2 Moderate	3 Severe, No Psychotic Behavior	4 Severe, with Psychotic Behavior	5 In Partial or Unspecified Remission	6 Full Remission

General Principles of Pharmacotherapy

- No agent has been proven to be superior to another in efficacy or time to response.
- Use what has worked for the patient in the past.
- The most common cause of treatment failure is an inadequate medication trial.
- If no response at 4-6 weeks, consider switching, combining or augmenting the pharmacotherapy.
- SSRIs are agents of first choice due to ease of use, more tolerable side effects and safety in overdose.
- Counsel pregnant women and those considering pregnancy. The potential risks and benefits of pharmacotherapy must be weighed.

Managing Medication Side Effects

- Insomnia - Consider Diphenhydramine at HS or a brief trial of a short-acting non-addictive BZ receptor-binding agent, then reassess.
- Akathisia - Associated with newer antidepressants. Consider adding a small dose of clonazepam (0.5 mg q HS) or propanolol (10-20 mg bid/tid).
- Sexual dysfunction - Common with all SSRIs and others. Bupropion is least likely to produce this side effect.

General Principles of Psycotherapy

- Evidence-based psychotherapies and antidepressant medication are equally effective for most patients across the spectrum of depressive patients seen in outpatient settings, and either medication or one of the evidence-based psychotherapies should be considered as first line treatment in most cases.
- Evidence-based psychotherapies for depression are all brief, focused on current concerns, and help the patient learn new skills or alter patterns of behavior.
- Patients must be active psychotherapy participants who attend sessions consistently and follow through on action plans between sessions.
- If patient is not engaged in therapy after 6 weeks or is worse, consider antidepressant medication as addition or alternative.
  If patient is not improved after 12 weeks, medication should become a component of treatment.
- Combination of psychotherapy and medication should be tried for patients who have not responded to either approach alone during the current episode or who have responded well to combination therapy in prior episodes.

Evidence-based Types of Short-Term Psychotherapy

- Interpersonal Psychotherapy
- Behavior Therapy
- Cognitive Therapy
- Short-term Psychodynamic Psychotherapy. Less evidence regarding this approach is available
- Marital Therapy

WHAT YOU and YOUR FAMILY SHOULD KNOW ABOUT DEPRESSION

- **What is Major Depression?** - An illness that may be associated with biochemical changes in brain function. More than just a feeling of sadness, it affects day-to-day thoughts, feelings, actions, and physical well-being.
- **Myths** - Major depression is not a trivial disorder, will usually not go away on its own and is not the result of personal weakness, laziness or lack of will power.
- **Incidence** - Depression is a common illness affecting one out of every 20 people sometime in their lifetime.
- **Risk Factors** - Females, people with a first-degree relative with depression, a history of drug or alcohol misuse or a history of anxiety or eating disorders have an increased chance of having depression.
- **Treatment Response** - Depression responds well to treatment. People do get better.
- **Treatment Options** - Include antidepressant medication, psychotherapy, or a combination of the two. Sometimes treatment is done in primary care or family practice and sometimes in a mental health clinic, depending on your individual circumstances.
- **Outpatient vs Inpatient Care** - Most people with depression are successfully treated as outpatients. Inpatient hospitalization is generally reserved for patients with very severe symptoms.
- **Consultation/Referral** - Frequently a treatment team approach is used. A combination of treatments might work best, especially if the depression is severe or lasts a long time or the first treatment did not work well.
- **Medications** - Antidepressant medication takes a few weeks to get the full effect. It won't work if you don't take it consistently. Don't worry it's safe and not addicting.
- **Medication Side Effects** - Discuss side effects or other problems with your provider. Most problems can be resolved.
- **Treatment Takes Time** - Be consistent. Stick to your treatment plan. Follow-up with all scheduled appointments. Follow through on treatment steps or homework assignments. Remember, medication must be taken as directed, including dosage, frequency and length of time prescribed.
- **Don't** - Drink alcohol, self-medicate, or blame yourself. Talk with your provider before making major life decisions or changes during treatment.
- **Do** - Get plenty of rest, exercise, eat regularly, socialize.
- **Suicide** - Thoughts of death often accompany depression. Discuss these thoughts with your provider. If your provider is not available, seek immediate emergency care or tell a trusted friend or relative who can help you get professional help right away.
- **Communication** - Work with your provider. Discuss treatment options. Ask questions about treatment and talk about any concerns you may have. Discuss with your provider your feelings, activity, sleep and eating patterns, as well as unusual symptoms or physical problems.
- **Recurrence** - Depression may be recurrent. Maintenance antidepressants or booster therapy sessions may be needed for long-term health.

Treatment manuals available for evidence-based approaches to psychotherapy for depression:

COGNITIVE THERAPY:

Burns, D.D. (1999). Feeling good (Rev.).
New York: New American Library.

Burns, D.D. (1999). The feeling good handbook (Rev.).
New York: New American Library.

Gilson, M. & Freeman, A. (2000). Overcoming depression: A cognitive therapy approach for taming the depression BEAST.
San Antonio, TX: Psychological Corporation.

COGNITIVE-BEHAVIORAL THERAPY:

Lewinsohn, P.M., Muñoz, R., Youngren, M.A., & Zeiss, A.M. (1986).
Control your depression: 2nd edition.
Englewood Cliffs, N.J.: Prentice-Hall.

INTERPERSONAL THERAPY:

Weisman, M.M (1995). Mastering depression through interpersonal psychotherapy. San Antonio, TX: Psychological Corporation.
(includes a booklet of monitoring forms).